iiTS #

DMH Use Only
07/14/05

Department of Mental Health
iiTS- Community Event Report Form-MRDD

All incidents must be reported to the regional center immediately, unless otherwise specified on this form. The written event report form must be submitted the next working day, unless requested sooner by the regional center.

EVENT CATEGORY *(check one)*	**1.**		**INCIDENT**		**MEDICATION ERROR**		**DEATH**				
PROGRAM CATEGORY *(check one*	**2.**		**COMMUNITY PLACEMENT**		**PURCHASE OF SERVICE (POS)**		**CASE MANAGEMENT**				
3.	**Event Date & Time**				AM		PM				
		Month Day Year		Time							
4. Discovery Date & Time (Complete this section only if different than event date/time)							AM		PM		
			Month Day Year		Time						

INVOLVED

5. Consumer Name (Last)	**First**	**(MI)**	**6. DOB**	**7. Male/ Female**	**8. Consumer ID**

9. Address/Home	**Telephone Number**	**10. DMH/County Board Service Coordinator Name**

11. Event Location or where discovered (Name of agency or location)	**12. Name of Provider Agency/Organization involved in event & VENDOR NUMBER**

13. Persons who witnessed or have direct knowledge of the event

Last Name	First Name	Relationship* (below)	Telephone Number

*Relationship to Consumer-consumer, parent/guardian, staff, visitor, volunteer, complainant, perpetrator, reporter, victim, witness, other -specify)

14. NOTIFIED: Persons /Agencies *(Check all that apply)*	**Name of Person Contacted**	**DATE**	**TIME**				
DMH Regional Center				AM		PM	
Family or Guardian				AM		PM	
Physician				AM		PM	
Law Enforcement				AM		PM	
DSS Children's Division				AM		PM	
Division of Senior Services				AM		PM	
911				AM		PM	
Other				AM		PM	

15. EVENT DESCRIPTION: **Describe what happened and interventions used by staff:** – Refer to instruction sheet for items to be included in this section. *Attach additional pages if necessary.*